CITY OF LONG BEACH
Health and Dental Coverage Continuation
COBRA Election Form

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Social Security #: _____ Phone #: _____

Existing Health Plan: _____ Existing Dental Plan: _____

Type of Qualifying Event: _____ Termination/Reduction of hours _____ Employee Death
_____ Divorce _____ Former Dependent Child

Date of Qualifying Event: _____ Effective Date Cobra Coverage Begins: _____

Continue Coverage For: _____ Employee (& Dependents) Date Coverage Ends: _____
(18 months, 29 months if disabled)

Continue Coverage For: _____ Spouse _____ Child Date Coverage Ends: _____
(36 months)

Eligible Applicant's Name: _____ Social Security #: _____
(if not employee)

Address: _____
Street City State Zip Code Phone #

All checks or money orders must be made out to the City of Long beach for the TOTAL amount indicated below and mailed to Human Resources, Employee Benefits Section, 13th Floor, 333 West Ocean Boulevard, Long Beach, CA 90802. **Please write the word "COBRA" on the check or money order.**

MONTHLY AMOUNT:		With Dental	Without Dental
Health (Carrier Name)	_____	$ _____	$ _____
Dental (Carrier Name)	_____	$ _____	
Admin. Cost (2%/50%)	City of Long Beach	$ _____	$ _____
	TOTAL	$ _____	$ _____

You may continue your health and dental coverage by signing and dating this election form, completing the attached enrollment forms and by paying the Continuation Payment indicated above.

NOTE: Your continuation payment(s) indicated above are due within **45 days** of the date you sign this form. Benefits will not be available until all paperwork and premiums are received and processed.

Your beginning payment must include all premiums due from the effective date through the month in which payment is received. Thereafter, **monthly premiums are due no later than the twentieth (20th) of the month prior to the month of coverage.**

Failure to make payments in a timely manner can result in your coverage being cancelled.

Please indicate whether or not you wish to continue your group health and/or dental coverage and return one copy of this form to your Departmental Payroll/Personnel Assistant.

_____ I request continuation of my coverage under the group plan(s) named above for which I was covered on the date of eligibility.

_____ I do not wish to continue my coverage.

_____ _____
Applicant's Signature Date

_____ _____
Departmental Payroll Clerk's Signature Date